

Return this form to:

Treatment and Assessment Plan (OCF-18)

Use this form for accidents that occur on or after November 1, 1996.

**Claim Number:

**Policy Number:

Date of Accident:
(YYYYMMDD)

NOTE: A Treatment and Assessment Plan (OCF 18) is not required to make the following claims:

- ambulance or other goods or services provided on an emergency basis not more than 5 business days after the accident
- drugs prescribed by a regulated health professional
- goods with a cost of \$250 or less per item
- dental goods or services (submitted on the Standard Dental Claim Form)

If this is an impairment that comes within the Minor Injury Guideline (for accidents that occurred on or after September 1, 2010), or within a Pre-approved Framework Guideline (for accidents that occurred before September 1, 2010), an OCF – 23 Treatment Confirmation Form is required instead of this form.

To the Applicant:

Please provide information for the completion of Parts 1 and 2 and 3. After your regulated health professional has reviewed your Treatment and Assessment Plan with you, sign Part 10.

Your regulated health professional will complete all other parts of the form.

Collection, use and disclosure of this information are subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the manner in which the information is used and disclosed.

As indicated on the form, all attachments are sent directly to the insurer.

All fields must be completed subject to the following exceptions:

*required if known

**at least one field in this section

***optional

To the Regulated Health Professional/Facility:

To the extent possible, this Treatment and Assessment Plan should include all goods and services contemplated by the regulated health professional referred to in Part 5.

A health practitioner (i.e., chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist) must sign Part 4.

Consent: It is the responsibility of regulated health professionals to ensure that their collection, use and disclosure of information submitted are authorized by a consent form. Ontario Claims Form 5 (OCF – 5) *Permission to Disclose Health Information* may be used as a consent form.

**Part 1
Applicant
Information**

To be provided by the applicant

Date Of Birth (YYYYMMDD)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	*Telephone Number	Extension
Last Name			
First Name		***Middle Name	
Address			
City		Province	Postal Code

**Part 2
Insurance
Company
Information**

To be provided by the applicant

Insurance Company Name		City or Town of Branch Office (if applicable)	
*Adjuster Last Name		*Adjuster First Name	
*Adjuster Telephone		Extension	*Adjuster Fax
**Name of Policy Holder same as Applicant <input type="checkbox"/> OR:	**Policy Holder Last Name	*Policy Holder First Name	

**Part 3
Other
Insurance
Information**

To be completed by the regulated health professional referred to in Part 5 with information from the applicant

OTHER INSURANCE: Is there other insurance coverage for any goods and services listed in this Treatment and Assessment Plan?
I have made reasonable enquiries of the applicant and have determined that:

NO *There is no other insurance coverage identified for these goods and services* **YES** *There is other insurance coverage that is potentially available to cover/partially cover these goods and services.*

MOH	Is there Ministry of Health and Long-Term Care (MOH) coverage for any goods and services included in this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Other Insurer 1	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier
Other Insurer 2	*Other Insurer Name	*Other Insurance Plan Or Policy Number
	*Name of Plan Member	*Other Insurer's Identifier

Part 4 Signature of Health Practitioner Treatment and Assessment Plan Certification	Name of Health Practitioner		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City	Province	Postal Code		
	Telephone Number	*Extension	*Fax Number		
	*Email Address				
	<p>For accidents that occurred before September 1, 2010: Is this an impairment referred to in a Pre-approved Framework (PAF) Guideline? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain, in accordance with the PAF Guideline, and with express reference to the provisions of the PAF Guideline on which you rely, why this OCF-18 Treatment and Assessment Plan is being submitted instead of an OCF 23 Treatment Confirmation Form:</p> <p>For accidents that occur on or after September 1, 2010: Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain and provide compelling evidence why the applicant does not come within the Minor Injury Guideline due to a pre-existing medical condition that will prevent the applicant from achieving maximal recovery from the minor injury if the applicant is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.</p> <p style="text-align: right;">Send any attachments directly to the insurer</p>				
<p>I confirm that, to the best of my knowledge, the information in this Treatment and Assessment Plan is accurate, the Treatment and Assessment Plan has been reviewed with the applicant by the regulated health professional in Part 5, and the goods and services contemplated are reasonable and necessary for the treatment and rehabilitation of the applicant for the injuries identified in Part 6.</p> <p>I UNDERSTAND THAT IT IS AN OFFENCE UNDER THE INSURANCE ACT to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance.</p> <p>I FURTHER UNDERSTAND THAT IT IS AN OFFENCE UNDER THE FEDERAL CRIMINAL CODE for anyone by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and DETECTING AND PREVENTING FRAUD.</p>					
Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)	

Part 5 Signature of Regulated Health Professional Treatment and Assessment Plan Preparation and Supervision If same person as Part 4 check here <input type="checkbox"/> and DO NOT COMPLETE Part 5	Name of Regulated Health Professional		College Registration Number		You are a: <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Nurse <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____
	Facility Name (if applicable)		AISI Facility Number (if applicable)		
	Address				
	City	Province	Postal Code		
	Telephone Number	*Extension	*Fax Number		
	*Email Address				
	<p>I CONFIRM THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.</p> <p>I UNDERSTAND THAT IT IS AN OFFENCE UNDER THE INSURANCE ACT to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance.</p> <p>I FURTHER UNDERSTAND THAT IT IS AN OFFENCE UNDER THE FEDERAL CRIMINAL CODE for anyone by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.</p>				
Name of Regulated Health Professional (please print)		Signature of Regulated Health Professional		Date (YYYYMMDD)	

**Part 9
Plan Goals,
Outcome
Evaluation
Methods
and Barriers
to Recovery**

a) Goals:
 (i) Identify the goal(s) in regard to the applicant's impairment(s), symptom(s) or pathology that this Treatment and Assessment Plan seeks to achieve:
 pain reduction increased range of motion
 increase in strength other(s)/not applicable (please specify)

and

(ii) Select the functional goal(s) that this Treatment and Assessment Plan seeks to achieve:
 return to activities of normal living return to pre-accident work activities
 return to modified work activities other(s)/not applicable (please specify)

b) Evaluation:
 (i) How will progress on the goal(s) in a) (i) and a) (ii) be evaluated?

(ii) *If this is a subsequent Treatment and Assessment Plan, what was the applicant's improvement at the end of the previous plan based on your evaluation method?

Send any attachments directly to the insurer

c) Barriers to recovery:
 (i) Have you identified any other barriers to recovery? No Yes (please explain)

(ii) *Do you have any recommendations and/or strategies to overcome these barriers? No Yes (please explain)

d) Concurrent Treatment:
 Are you aware if any concurrent treatment not included in this Treatment and Assessment Plan will be provided by any other provider/facility?
 No Yes (please explain)

**Part 10
Signature of
Applicant**

Must be completed unless waived by insurer

I have reviewed and agree with this Treatment and Assessment Plan. I understand that payment for this Treatment and Assessment Plan is subject to the approval of the insurer.

In the event that my insurer does not agree to pay for all the goods and services contemplated in this Treatment and Assessment Plan, I understand that an examination may be required to determine my eligibility to the goods and services outlined or this Treatment and Assessment Plan.

In the event that an examination is requested, I authorize my insurer and my health care providers to give the person identified by the insurer to review this application only such information relating to my health condition, treatment and rehabilitation received as a result of the accident, as is reasonably required for the purposes of determining my eligibility to benefits.

As required by law, a copy of the examination report as well as the insurance company's determination will be sent to me.

Subject to the Statutory Accident Benefits Schedule, in those circumstances where prior approval is required, I understand that if I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

I UNDERSTAND THAT IT IS AN OFFENCE UNDER THE INSURANCE ACT to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance.

I FURTHER UNDERSTAND THAT IT IS AN OFFENCE UNDER THE FEDERAL CRIMINAL CODE for anyone by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
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Applicant Name:		OCF-18 INSURER FAX BACK	Policy Number:	
Provider Name:			Claim Number:	
Provider Fax:			Date of Accident:	

Part 11 Health Care Providers	Provider Reference	†Provider Type	Provider		Regulated (College Registration Number)	Unregulated (AISI Number if applicable, or blank)	Hourly Rate (if applicable)
			Last Name	First Name			
A							
B							
C							
D							
E							
F							

Part 12 Proposed Goods or Services Requiring Insurer Approval	G/S Ref	Description	†Code	†Attribute	Provider Ref	Estimated			Projected	
						Quantity	†Measure	Cost	Total Count	Total Cost
	1									
	2									
	3									
	4									
	5									
	6									
	7									
	8									
	9									
	10									
	11									
	12									
	13									
Estimated duration of this Plan:						Weeks	Sub-Total:			
*How many visits have you already provided:						*visits	Minus MOH:			
Note: † Refer to the User Manual coding guidelines posted at www.hcaiinfo.ca . Attributes codes are used to further qualify the service codes and are described in the manual. Payment by auto insurer is secondary to available collateral benefits.							Minus Other Insurer 1+2:			
							TAX (if applicable):			
							Auto Insurer Total:			

*Please indicate any additional comments regarding proposed goods and services:

Are there any attachments? Yes No
 If Yes, how many? _____
 Send any attachments directly to the insurer

Part 13 Signature of Insurer	<input type="checkbox"/> ***I waive the requirement of the Applicant's signature.	
	I have reviewed this Treatment and Assessment Plan and based upon the information provided, I:	
	<input type="checkbox"/> Approve this Treatment and Assessment Plan <input type="checkbox"/> Partially approve <input type="checkbox"/> Do not approve	
	The Statutory Accident Benefits Schedule states that the insurer shall, within 10 business days of receiving this Treatment and Assessment Plan, give the applicant a notice stating the goods and services contemplated by the Treatment and Assessment Plan for which the insurer will or will not pay.	
Name of Adjuster (please print)	Signature of Adjuster	Date (YYYYMMDD)
To the insurer: Please provide a copy of this page to the applicant, the Health Practitioner indicated in Part 4 and the Regulated Health Professional indicated in Part 5.		

Note: The fee for completing this form is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly. The Regulated Health Professional referred to in Part 5 will contact each of the health care providers listed in Part 11 and provide details of the services and other charges that have been approved and are payable under this Treatment and Assessment Plan.